Asylum Notes.

By R. M. PHELPS, M.D.,

Rochester, Minn.

Among the Hospital Reports.

Appended to the written report of each hospital for the insane are the statistical reports of clinical study. Unfortunately they are for the most part without any explanatory comment to make them clear.

As the report as a whole may not be wholly representative of the daily internal activity of the hospital, yet they are the most accurate indications we have, and as such, issued for the purposes of comparison, we would note some of the most important central topics there found.

Congregate Dining-rooms.—Custodial and building devices prevail in the reports. Under building ideas of custodial character, congregate dining-rooms or dining-rooms for congregating large numbers of the insane from diverse wards at meal time, have formed during the last decade a prominent idea. It is a live question at present. Dr. Rogers (Longcliff, Ind.,) has for a year or more had a congregate dining-room, and reports in favor of them, although not for over 50 per cent. of his patients. Dr. Tobey (Toledo, Ohio,) has advocated them most enthusiastically. Dr. White (Milwaukee) has also favored them very much.

On the other hand, Dr. Ratcliff (Dayton, Ohio,) says, "In his judgment they fail to accomplish the purpose desired." Dr. Burgess (Montreal) speaks very decidedly "that from twenty years of experience with both systems of dining-rooms, I infinitely prefer the separate." Dr. Russell (Hamilton, Ont.,) is not only emphatic, but shows the more powerful argument, in that he has been to the trouble of changing back to separate dining-rooms.

Briefly and fairly stated, the various arguments found in reports at various times are about as follows:

1. It costs less to build one large dining-room than many small ones. This is economy in "first cost."

2. Economy in "scraps" or "waste" is said to be greater in one large dining-room.

3. The physician can supervise the diet better.

4. Meals can be put on warmer and with fewer waiters.

5. In a vague way it is claimed to be good for the patients to get out three times daily in their trips to and from the dining-room; seemingly by reason of the change and ventilation.

Contra Arguments.—1. The cost in original saving of one large dining-room over that of several small ones, is not yet proven by figures.

The method of figuring by the saving of beds is rather fallacious. If a congregate dining-room for 500 be estimated at $15,000, then an equal amount of room on the wards, estimated by proportional costs, and of the same construction, would probably cost not quite so much.

2. Economy in "scraps" is not enough to have much weight.

3. The greater supervision is a valid argument, but of not enough value to outweigh any disadvantages.

4. The only saving of warmth to meals is by having the kitchen near at hand (say two to four minutes).

5. The grouping of people of diverse habits, neatness, violence, and tastes is offensive and directly against the whole modern idea of individualization.

6. The trip for the people up and downstairs, the outdoor exposure in all weather, the waiting to congregate and form in line, is a great disadvantage and very unhomelike.

7. It leads one to classify according to dining-room attendance, which interferes with other essentials in classification.

Cottage System.—The next most important element discussed is the cottage system, or the building of detached cottages instead of one large building.

This construction has been a popular and prevailing ideal for the past ten years. Kankakee, Toledo, Athens, Jamestown and others have been leading. The arguments in favor of cottages are greater subdivision and classification of patients, and a more homelike form of living.

Even in pursuance of these praiseworthy ideas, how-

ever, it would seem to be the fact, that the separation can be as complete, and the classification fully as perfect in form by adjustment upon wards, as by adjustment in separate buildings. The expense and difficulty of heating, the difficulties of supervision, of feeding and furnishing, are the objections to the cottage system. By having short pavilions between the wards and buildings, and by having them somewhat lower and more spread out, it would seem possible to secure the desired subdivision as well.

It will always be cheaper and less difficult to supervise one building than a small village of cottages. The best mode of building is still to be considered an open, debatable question, and one which should be discussed very thoroughly by those intending building.

Medical Work.—Progress is being made, as shown by various reports.

And if only "progress" be the watchword, high attainment is secured. The best worded statement, perhaps, is found in the report of Clarke Gapen, the new superintendent of Kankakee, Ills. He says:

"The medical and nursing staff have undergone many changes, but throughout have maintained a high average of proficiency. During the past year, especial effort has been made by the medical staff, to qualify itself for its high and difficult work, by courses of study in histology and pathology of the brain, under the direction of Dr. Meyer, and in close analytic study of diseases of the mind in general, and especially of the cases coming under treatment.

"A determined effort has been made on the part of the medical staff, not only to know the newest and best that science in any part of the world had to offer, but to do the best that the art of medicine could invent for the amelioration of bodily and mental afflictions with which we are surrounded.

"Rarely, I believe, in the history of American hospitals, has a more united and spirited effort been made to obtain high scientific and philanthropic results. Daily meetings of the medical staff have been held to report to the superintendent the conditions prevailing in all departments of this great hospital, to consult together how best to obtain desired results, and together examine and study critically the more complicated and difficult cases. I can be all the more unstinted in my praise, for the reason that my own energies have

been largely absorbed in economic and constructive reform, and in my relations to this part of the work, mainly that of general direction."

P. M. Wise (Hudson River Hospital, N. Y.,) outlines also similar revivalistic measures of the past two years, and gives papers written by the staff, each one of whom investigated along some special line. He had a daily consultation hour and kept up the training school. Such reports as these seem the result of a common sense study, made from an inside position, and are, therefore, probably the best answers made yet to Dr. Mitchell's criticisms. In these reports, moreover, the element of the assistant physician is made prominent. If, as they themselves claim, the superintendent must be mainly a business man, then the one having charge of the nursing, the medical and the scientific work, ought to rank up, so that able men be secured. The general administrative ability must be most able as a matter of course, but the other, the medical and scientific, seems to be the ones most liable to be neglected in our State hospitals.

Catonsville, Md., and Tuscaloosa, Ala., have not the clinical reports of preceding years. The Government Hospital and Norristown Hospital have pathological reports, though not made by the staff.

The Michigan reports (of Pontiac and Traverse City) review the medical work in an instructive way. Indeed, a review of the work which the report covers, with comments, would seem to be the more logical function of a report than would be the publishing of essays.

Middletown Hospital, N. Y., has an essay attempting to prove the correlation of physical and psychical abnormalities. This is the result of a three months' study by a physician not on the regular staff. Long lists of measurements are given, among which we may mention "irregular ears," "irregular ears immoderately," "flat ears," "flat ears immoderately," "face masculine," "feminine," "asymmetrical," "nose situated too low," "depression on occipital fontanelle," "depression over one or more sutures," "occiput irregular," etc., etc. One thousand insane are compared with 110 sane people.

Many other hospitals doubtless are doing extra routine work which is not noted in the reports. Indeed, we know of over a dozen. The spirit of research and competitive work is growing.

General Paresis.—Among the clinical tables so variable is the personal equation, that we cannot select many

topics. Perhaps concerning general paresis we can learn something, as it is the most thoroughly definite disease entity in the classification tables.

Hospitals report variously. We note the following as being the most frequent and least frequent of the proportion of paretics to admissions as given in the reports so far received:

Of those reporting more than one paretic to twenty admissions, we have:

Pontiac,	1 to 8.3.
Danvers, Mass.,	1 to 8.5.
Westboro, Mass.,	1 to 11.
Traverse City, Mich.,	1 to 14.
Taunton, Mass.,	1 to 14.
Rochester, Minn.,	1 to 15.
Kalamazoo, Mich.,	1 to 17.

Of those reporting less than one paretic to one hundred admissions, we have:

Austin,	0 to 126.
Warren, Pa.,	1 to 250.
Catonsville, Md.,	1 to 109.
Mt. Hope, Md.,	1 to 160.
Norfolk Neb.,	1 to 130.
Petersburg, Va.,	0 to 176.

The above shows evidently no distribution by city population, or by section of the country and, in fact, gives no clue based upon ordinary causes. Of course, the personal equation of the physician making the judgment has some effect, as well as the fact that some cases not diagnosed on admission as paretics, are so designated later. A judgment based upon the number of deaths would be more accurate, if only paretics were always noted in those cases. Still, there is doubtless a capricious variability about the disease not yet fully studied.

As to causation, although one can always hold a suspicion of syphilis, yet is only proven in a minority of cases. [List of Reports not yet complete.]